




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-322-4953 or visit www.MUSTbenefits.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-322-4953 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u> ? | \$2,000 person / \$4,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Prescription drugs</u> , diabetic education, initial accident care benefit, travel benefit, breast pumps, mammograms, and <u>preventive</u> health and well-child are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$4,000 person / \$8,000 family <u>Prescription drug limit</u> : \$1,650 person / \$3,300 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.bcbsmt.com or call 1-855-322-4953 for a list of participating <u>providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a referral. |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Virtual visits available through MDLIVE: 20% <u>coinsurance</u> . |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge; <u>deductible</u> does not apply | 20% <u>coinsurance</u> | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Coverage for a pap test limited to 1 per <u>plan</u> year. Coverage for colonoscopy limited to 1 every 10 years beginning at age 50. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |

* For more information about limitations and exceptions, see the plan or policy document at www.MUSTbenefits.org.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MUSTbenefits.org | Preferred generic drugs | Retail: \$10 <u>copay</u> Mail: \$30 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$10 <u>copay</u> ; <u>deductible</u> does not apply | <u>Prescription drug out-of-pocket limit</u> : \$1,650 person / \$3,300 family Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription at a <u>plan approved mail order pharmacy</u>); 90-day supply (retail extended supply <u>network pharmacy</u>). <u>Specialty drugs</u> covered up to a 30-day supply. <u>Extended Supply Network copayments</u> are three times retail <u>copayments</u> . |
| | Non-preferred generic drugs | Retail: \$30 <u>copay</u> Mail: \$90 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$30 <u>copay</u> ; <u>deductible</u> does not apply | |
| | Preferred brand drugs | Retail: \$50 <u>copay</u> Mail: \$150 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$50 <u>copay</u> ; <u>deductible</u> does not apply | |
| | Non-preferred brand drugs | Retail: \$150 <u>copay</u> Mail: \$450 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply | |
| | Preferred <u>Specialty drugs</u> | Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$150 <u>copay</u> ; <u>deductible</u> does not apply | |
| | Non-preferred <u>Specialty drugs</u> | Retail: \$300 <u>copay</u> ; <u>deductible</u> does not apply | Retail: \$300 <u>copay</u> ; <u>deductible</u> does not apply | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> required. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | The <u>plan</u> pays the first \$500 of eligible expenses for accident injuries; <u>deductible</u> and <u>coinsurance</u> waived. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |

* For more information about limitations and exceptions, see the plan or policy document at www.MUSTbenefits.org.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> required. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | First 3 visits per <u>plan</u> year not subject to <u>deductible</u> and <u>coinsurance</u> . Subsequent visits 20% <u>coinsurance</u> . |
| | Inpatient services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> required. |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Cost sharing does not apply for <u>preventive</u> services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | <u>Preauthorization</u> required. |

* For more information about limitations and exceptions, see the plan or policy document at www.MUSTbenefits.org.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 180 day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> required. |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Outpatient physical, occupational, speech, and cardiac therapies have a combined 50 visit maximum per benefit period. Inpatient physical, occupational, speech, and cardiac therapies have a combined 60 day maximum per benefit period. <u>Preauthorization</u> required for inpatient therapies. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | No Applied Behavior Analysis (ABA) benefits for Autism Spectrum Disorder available for members 19 years of age or older. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 60 days maximum per benefit period. <u>Preauthorization</u> required. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | 180 day combined maximum for <u>home health care</u> and <u>hospice</u> . <u>Preauthorization</u> required. |
| If your child needs dental or eye care | Children's eye exam | No Charge; <u>deductible</u> does not apply | No Charge; <u>deductible</u> does not apply | Limited to 1 exam per benefit <u>plan</u> year. |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

* For more information about limitations and exceptions, see the plan or policy document at www.MUSTbenefits.org.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbsmt.com.
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-855-322-4953, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-855-322-4953 or visit www.bcbsmt.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-322-4953.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-322-4953.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-322-4953.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-322-4953.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,000 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,060 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$200 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$3,160 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,000 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,000 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,000 |

The plan would be responsible for the other costs of these **EXAMPLE** covered services.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>